

PRIMARY CONDITION DETAILS

Complete a copy of this page for each location of pain, dysfunction, or concern.

Describe **ONE and ONLY ONE** body part per page.

Define location (Write **ONE and ONLY ONE** word) _____ EXAMPLES: "jaw", "ear", "tongue", "mouth", "tooth"

Problem Occurs: (check **ONE**) Left side only Right side only Both sides Switches sides

First Noticed: (Date) _____ Describe original onset:

Trauma: (list years occurred) Auto accidents: _____ Falls: _____ Blows to head: _____

Print from website and complete additional forms (motor vehicle accident and/or trauma) to provide details.

Pain Levels: Average (check **ONLY one**) None Mild Moderate Severe

Worst pain: (circle **ONE** number) no pain 0 1 2 3 4 5 6 7 8 9 10 most pain ever

Least pain: (circle **ONE** number) no pain 0 1 2 3 4 5 6 7 8 9 10 most pain ever
Circle 0 if not constant pain

Average pain: (circle **ONE** number) no pain 0 1 2 3 4 5 6 7 8 9 10 most pain ever

Type of pain: (check all that apply) Dull Sharp Deep Superficial Burning Aching
 Shooting Tingling Throbbing Crawling Other:

Since it started, it is: Same Better Worse If worse, increased: Frequency Severity Duration

Definitions: How often pain occurs (1/day or 1/week) **Constant:** How often the pain flares (1/day or 1/week)

If episodic, onset is: Gradual Abrupt If constant, flares occur: Gradually Abruptly

Frequency of episodes or flares: (number) _____ Times per: (check only one) Day Week Month

Duration of episodes or flares: (indicate **only one**) _____ Seconds _____ Minutes _____ Hours

Worst time of day: (check **one**) Awakening Morning Afternoon Evening Night Sleeping

Worse as the day progresses? Yes No Better as the day progresses? Yes No

Worse on school days? Yes No If work or do work at home-affect pain Yes No

Does condition interrupt sleep? Yes No Family members with same concern? Yes No

What increases the problem? (check **all that apply**) Chewing Yawning Talking Biting
 Physical activity Clenching Touching face Opening wide Certain foods Weather Stress
 Emotional upset Cold liquids Head movement Menstruation Other:

What decreases the problem? (check **all that apply**) Relaxation Sleep Exercise Soft diet
 Massage Heat Cold Other:

Medications that help: (names, dosage)

Medications and Therapies that DID NOT help: (names, dosage)

Healthcare Providers who have treated: (name, specialty, treatment provided)

What lifestyle changes have been made due to pain/dysfunction?

What else do is noticed when the condition occurs? Describe any additional concern that occurs with or because of primary condition. **If it is a separate pain or concern, complete an additional form. If you are not sure, report separately.**